TLD (Radiation Badge) Request Form

Name: Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIN #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex (M/F): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I completed “Radiation Safety” on Medworks successfully: Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

By signing below, I acknowledge:

1. The information provided above is accurate
2. I have read and understand the attached document “Monitoring Radiation Exposure”
3. I will wear my TLD badges when I am present during procedures involving the use of x-ray equipment

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Employee Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Department Manager Date

This form must be returned to the Radiation Safety Office upon completion.

All information on this form will be kept confidential.

For questions or assistance, please contact Mike Gasparotto at extension 4353 or [gasparom@tbh.net](mailto:gasparom@tbh.net)

**Radiation Safety Only**

Date Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LOC#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wearer #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_